Device Errors

Enteral feeding tubes

CHECK CAREFULLY TO AVOID MISCONNECTING THESE DEVICES.

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A 67-YEAR-OLD MAN HOSPITALIZED FOR DEHYDRATION HAD an enteral feeding tube placed. A few hours later, he complained of pain. Assessing him, the nurse found his abdomen distended. The oxygen tube was connected to the patient's feeding tube. The patient became unresponsive and suffered a cardiac arrest. Although he was successfully resuscitated, his condition deteriorated and he later died of sepsis. A later investigation couldn't determine how the misconnection occurred.

What went wrong?

Potentially harmful misconnections between enteral feeding sets and rigid female luer connections aren't new, but they continue to occur. The FDA has received many reports of rnisconnections of enteral feeding sets with parenteral administration sets, indwelling I.V. catheters or ports, epidural catheters, balloon inflation ports, and oxygen delivery systems.

What precautions can you take?

- Become familiar with the device labeling.
- Examine interconnections to make sure they're compatible.
- Use the correct fittings and connect them according to the manufacturer's instructions.
- Check feeding administration sets when your shift begins and then often to make sure that solutions are being delivered safely.
- Supervise the patient closely during enteral feeding.
- Make sure that no rnisconnections occur when the patient gets out of bed or during transport.
- Tape all connections to keep enteral feeding tubes correctly aligned and connected. If a connection becomes dislodged, make sure that a qualified person reconnects it proper1y.

Use additional safety measures, such as color coding all connections.

- Don't use adapters that can be rnisconnected with enteral feeding tubes.

Although you need to support the adverse event–reporting policy of your health care facility, you may voluntarily report a medical device that doesn't perform as intended by calling MedWatch at 1-800-FDA-1088 (fax: 1-800-FDA-0178). The opinions and statements contained in this report are those of the author and may not reflect the views of the Department of Health and Human Services. Device *Errors* is coordinated by Chris Parmentier, RN.